



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ANESTHESIA ALLIANCE OF DALLAS, P.A.

Respondent Name

TRANSPORTATION INSURANCE CO

MFDR Tracking Number

M4-17-0961-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

DECEMBER 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has issued a payment for our service but not the correct allowable per the 2016 Texas Workers Compensation fee schedule."

Amount in Dispute: \$68.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains that no additional allowable is due."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2016	Anesthesia Services CPT Code 00920-QZ	\$68.18	\$68.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - Z664-Reimbursement is calculated using base units plus time units.
 - P300-The amount paid reflects a fee schedule reduction.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.
 - W3-Request for reconsideration.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for code 00920-QZ?

Findings

28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code 134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other.

28 Texas Administrative Code §134.203(c)(1) states, "...To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification...For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$53.68..."

The requestor billed CPT code 00920 defined as "Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified."

The requestor billed the disputed anesthesiology service using the "QZ" modifier that is described as "CRNA service: without medical direction by a physician."

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

The Division reviewed the submitted medical bill and finds the anesthesia was started at 0819 and ended at 0928, for a total of 69 minutes. Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services Section (50)(G) states, "Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place." Therefore, the requestor has supported $69/15 = 4.6$.

The base unit for CPT code 00920 is 3.

The DWC Conversion Factor for 2016 is \$58.62.

The MAR for CPT code 01830 is: (Base Unit of 4 + Time Unit of 4.6 X \$58.62 DWC conversion factor = \$445.51. Previously paid by the respondent is \$363.65. The difference between the MAR and amount paid is \$81.86. The requestor is seeking a lesser amount of \$68.18; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$68.18.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$68.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	12/28/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.